Guidelines for Preventing Workplace Violence for Health Care and Social Service Workers

U.S. Department of Labor
Occupational Safety and Health Administration

OSHA 3148
1998 (Revised)

Report Documentation Page

Report Date	Report Type	Dates Covered (from... to)
00001998	N/A	-

Title and Subtitle Guidelines for Preventing Workplace Violence for Health Care and Social Service Workers	**Contract Number**
	Grant Number
	Program Element Number
Author(s)	**Project Number**
	Task Number
	Work Unit Number
Performing Organization Name(s) and Address(es) U.S. Department of Labor Occupational Safety & Health Administration 200 Constitution Avenue Washington, DC 20210	**Performing Organization Report Number** OSHA 3148
Sponsoring/Monitoring Agency Name(s) and Address(es)	**Sponsor/Monitor's Acronym(s)**
	Sponsor/Monitor's Report Number(s)

Distribution/Availability Statement
Approved for public release, distribution unlimited

Supplementary Notes

Abstract
For many years, health care and social service workers have faced a significant risk of job-related violence. Assaults represent a serious safety and health hazard for these industries, and violence against their employees continues to increase. OSHAs new violence prevention guidelines provide the agencys recommendations for reducing workplace violence developed following a careful review of workplace violence studies, public and private violence prevention programs, and consultations with and input from stakeholders. OSHA encourages employers to establish violence prevention programs and to track their progress in reducing work-related assaults. Although not every incident can be prevented, many can, and the severity of injuries sustained by employees reduced. Adopting practical measures such as those outlined here can significantly reduce this serious threat to worker safety.

Subject Terms

Report Classification unclassified	**Classification of this page** unclassified
Classification of Abstract unclassified	**Limitation of Abstract** UU

Number of Pages
49

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Guidelines for Preventing Workplace Violence for Health Care and Social Service Workers

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Occupational Safety and Health Administration
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Contents

Notice

These guidelines are **not** a new standard or regulation. They are advisory in nature, informational in content, and are intended for use by employers seeking to provide a safe and healthful workplace through effective workplace violence prevention programs adapted to the needs and resources of each place of employment. The guidelines are not intended to address issues related to patient care. The guidelines are performance-oriented and the implementation of the recommendations will be different based upon an establishment's hazard analysis.

Violence inflicted upon employees may come from many sources—i.e., patients, third parties such as robbers or muggers—and may include co-worker violence. These guidelines address only the violence inflicted by patients or clients against staff. It is suggested, however, that workplace violence policies indicate a zero-tolerance for violence of any kind.

The Occupational Safety and Health Act of 1970 (OSH Act)[1] mandates that, in addition to compliance with hazard-specific standards, all employers have a general duty to provide their employees with a workplace free from recognized hazards likely to cause death or serious physical harm. OSHA will rely on Section 5(a) of the OSH Act, the "General Duty Clause,"[2] for enforcement authority. Employers can be cited for violating the General Duty Clause if there is a recognized hazard of workplace violence in their establishments and they do nothing to prevent or abate it. Failure to implement these guidelines is not in itself a violation of the General Duty Clause of the OSH Act. OSHA will not cite employers who have effectively implemented these guidelines.

Further, when Congress passed the OSH Act, it did so based on a finding that job-related illnesses and injuries were imposing both a hindrance and a substantial burden upon interstate commerce, "in terms of lost production, wage loss, medical expenses, and disability compensation payments."[3]

At the same time, Congress was mindful of the fact that workers' compensation systems provided state-specific remedies for job-related injuries and illnesses. Issues on what constitutes a compensable claim and what the rate of compensation should be were left up to the states, their legislatures, and their courts to determine. Congress acknowledged this point in Section 4(b)(4) of the OSH Act, when it stated categorically: "Nothing in this chapter shall be construed to supersede or in any manner affect any workmen's compensation law . . . ."[4] Therefore, these non-mandatory guidelines should not be viewed as enlarging or diminishing the scope of work-related injuries and are intended for use in any state and without regard to whether the injuries or fatalities, if any, are later deemed to be compensable.

[1] Public Law 91-596, December 29, 1970; and as amended by P.L. 101-552, Section 3101, November 5, 1990.

[2] "Each employer shall furnish to each of his employees employment and a place of employment which are free from recognized hazards that are causing or are likely to cause death or serious physical harm to his employees."

[3] 29 U.S.C. 651(a).

[4] 29 U.S.C. 653(b)(4).

Acknowledgments

Many persons, including health care, social services, and employee assistance experts; researchers, educators; unions, and other stakeholders; OSHA professionals; and the National Institute for Occupational Safety and Health (NIOSH) contributed to these guidelines.

Also, several states have developed relevant standards or recommendations, such as the California OSHA (CAL/OSHA), *CAL/OSHA Guidelines for Workplace Security,* and *Guidelines for Security and Safety of Health Care and Community Service Workers*; the Joint Commission on Accreditation of Health Care Organizations, *1995 Accreditation Manuals for Hospitals*; Metropolitan Chicago Healthcare Council, *Guidelines for Dealing with Violence in Health Care*; New Jersey Public Employees Occupational Safety and Health (PEOSH), *Guidelines on Measures and Safeguards in Dealing with Violent or Aggressive Behavior in Public Sector Health Care Facilities*; and the State of Washington Department of Labor and Industries, *Violence in Washington Workplaces,* and *Study of Assaults on Staff in Washington State Psychiatric Hospitals.* Information is available from these and other agencies to assist employers.

Introduction

For many years, health care and social service workers have faced a significant risk of job-related violence. Assaults represent a serious safety and health hazard for these industries, and violence against their employees continues to increase.

OSHA's new violence prevention guidelines provide the agency's recommendations for reducing workplace violence developed following a careful review of workplace violence studies, public and private violence prevention programs, and consultations with and input from stakeholders.

OSHA encourages employers to establish violence prevention programs and to track their progress in reducing work-related assaults. Although not every incident can be prevented, many can, and the severity of injuries sustained by employees reduced. Adopting practical measures such as those outlined here can significantly reduce this serious threat to worker safety.

OSHA's Commitment

The publication and distribution of these guidelines is OSHA's first step in assisting health care and social service employers and providers in preventing workplace violence. OSHA plans to conduct a coordinated effort consisting of research, information, training, cooperative programs, and appropriate enforcement to accomplish this goal.

The guidelines are **not** a new standard or regulation. They are advisory in nature, informational in content, and intended for use by employers in providing a safe and healthful workplace through effective violence prevention programs, adapted to the needs and resources of each place of employment.

Extent of Problem

Today, more assaults occur in the health care and social services industries than in any other. For example, Bureau of Labor Statistics (BLS) data for 1993 showed health care and social service workers having the highest incidence of assault injuries (BLS, 1993). Almost two-thirds of the nonfatal assaults occurred in nursing homes, hospitals, and establishments providing residential care and other social services (Toscano and Weber, 1995).

Assaults against workers in the health professions are not new. According to one study (Goodman et al., 1994), between 1980 and 1990, 106 occupational violence-related deaths occurred among the following health care workers: 27 pharmacists, 26 physicians, 18 registered nurses, 17 nurses' aides, and 18 health care workers in other occupational categories. Using the National Traumatic Occupational Fatality database, the study reported that between 1983 and 1989, there were 69 registered nurses killed at work. Homicide was the leading cause of traumatic occupational death among employees in nursing homes and personal care facilities.

A 1989 report (Carmel and Hunter) found that the nursing staff at a psychiatric hospital sustained 16 assaults per 100 employees per year. This rate, which includes any assault-related injuries, compares with 8.3 injuries of **all** types per 100 full-time workers in all industries and 14.2 per 100 full-time workers in the construction industry (BLS, 1991). Of 121 psychiatric hospital workers sustaining 134 injuries, 43 percent involved lost time from work with 13 percent of those injured missing more than 21 days from work.

Of greater concern is the likely underreporting of violence and a persistent perception within the health care industry that assaults are part of the job. Underreporting may reflect a lack of institutional reporting policies, employee beliefs that reporting will not benefit them, or employee fears that employers may deem assaults the result of employee negligence or poor job performance.

Risk Factors

Health care and social service workers face an increased risk of work-related assaults stemming from several factors, including:

- The prevalence of handguns and other weapons—as high as 25 percent[5]—among patients, their families, or friends. The increasing use of hospitals by police and the criminal justice systems for criminal holds and the care of acutely disturbed, violent individuals.
- The increasing number of acute and chronically mentally ill patients now being released from hospitals without followup care, who now have the right to refuse medicine and who can no longer be hospitalized involuntarily unless they pose an immediate threat to themselves or others.
- The availability of drugs or money at hospitals, clinics, and pharmacies, making them likely robbery targets.
- Situational and circumstantial factors such as unrestricted movement of the public in clinics and hospitals; the increasing presence of gang members, drug or alcohol abusers, trauma patients, or distraught family members; long waits in emergency or clinic areas, leading to client frustration over an inability to obtain needed services promptly.

[5] According to a 1989 report (Wasserberger), 25 percent of major trauma patients treated in the emergency room carried weapons. Attacks in emergency rooms in gang-related shootings as well as planned escapes from police custody have been documented in hospitals. A 1991 report (Goetz et al.) also found that 17.3 percent of psychiatric patients searched were carrying weapons.

- Low staffing levels during times of specific increased activity such as meal times, visiting times, and when staff are transporting patients.
- Isolated work with clients during examinations or treatment.
- Solo work, often in remote locations, particularly in high-crime settings, with no back-up or means of obtaining assistance such as communication devices or alarm systems.
- Lack of training of staff in recognizing and managing escalating hostile and assaultive behavior.
- Poorly lighted parking areas.

Overview of Guidelines

In January 1989, OSHA published voluntary, generic safety and health program management guidelines for all employers to use as a foundation for their safety and health programs, which can include a workplace violence prevention program.[6] OSHA's violence prevention guidelines build on the 1989 generic guidelines by identifying common risk factors and describing some feasible solutions. Although not exhaustive, the new workplace violence guidelines include policy recommendations and practical corrective methods to help prevent and mitigate the effects of workplace violence.

The goal is to eliminate or reduce worker exposure to conditions that lead to death or injury from violence by implementing effective security devices and administrative work practices, among other control measures.

The guidelines cover a broad spectrum of workers who provide health care and social services in psychiatric facilities, hospital emergency departments, community mental health clinics, drug abuse treatment clinics, pharmacies, community care facilities, and long-term care facilities. They include physicians, registered nurses, pharmacists, nurse practitioners, physicians' assistants, nurses' aides, therapists, technicians, public health nurses, home health care workers, social/welfare workers, and emergency medical care personnel. Further, the guidelines may be useful in reducing risks for ancillary personnel such as maintenance, dietary, clerical, and security staff employed in the health care and social services industries.

[6] OSHA's *Safety and Health Program Management Guidelines* (*Fed Reg* 54 (16):3904-3916, January 26, 1989), provide for comprehensive safety and health programs containing these major elements. Employers with such programs can include workplace violence prevention efforts in that context.

Violence Prevention Program Elements

There are four main components to any effective safety and health program that also apply to preventing workplace violence, (1) management commitment and employee involvement, (2) worksite analysis, (3) hazard prevention and control, and (4) safety and health training.

Management Commitment and Employee Involvement

Management commitment and employee involvement are complementary and essential elements of an effective safety and health program. To ensure an effective program, management and front-line employees must work together, perhaps through a team or committee approach. If employers opt for this strategy, they must be careful to comply with the applicable provisions of the National Labor Relations Act.[7]

Management commitment, including the endorsement and visible involvement of top management, provides the motivation and resources to deal effectively with workplace violence, and should include the following:

- Demonstrated organizational concern for employee emotional and physical safety and health.
- Equal commitment to worker safety and health and patient/client safety.
- Assigned responsibility for the various aspects of the workplace violence prevention program to ensure that all managers, supervisors, and employees understand their obligations.
- Appropriate allocation of authority and resources to all responsible parties.
- A system of accountability for involved managers, supervisors, and employees.
- A comprehensive program of medical and psychological counseling and debriefing for employees experiencing or witnessing assaults and other violent incidents.
- Commitment to support and implement appropriate recommendations from safety and health committees.

Employee involvement and feedback enable workers to develop and express their own commitment to safety and health and provide useful information to design, implement, and evaluate the program.

[7] Title 29 U.S.C., Section 158(a)(2).

Employee involvement should include the following:

- Understanding and complying with the workplace violence prevention program and other safety and security measures.
- Participation in an employee complaint or suggestion procedure covering safety and security concerns.
- Prompt and accurate reporting of violent incidents.
- Participation on safety and health committees or teams that receive reports of violent incidents or security problems, make facility inspections, and respond with recommendations for corrective strategies.
- Taking part in a continuing education program that covers techniques to recognize escalating agitation, assaultive behavior, or criminal intent, and discusses appropriate responses.

Written Program

A written program for job safety and security, incorporated into the organization's overall safety and health program, offers an effective approach for larger organizations. In smaller establishments, the program need not be written or heavily documented to be satisfactory. What is needed are clear goals and objectives to prevent workplace violence suitable for the size and complexity of the workplace operation and adaptable to specific situations in each establishment.

The prevention program and startup date must be communicated to all employees. At a minimum, workplace violence prevention programs should do the following:

- Create and disseminate a clear policy of zero-tolerance for workplace violence, verbal and nonverbal threats, and related actions. Managers, supervisors, co-workers, clients, patients, and visitors must be advised of this policy.
- Ensure that no reprisals are taken against an employee who reports or experiences workplace violence .[8]
- Encourage employees to promptly report incidents and to suggest ways to reduce or eliminate risks. Require records of incidents to assess risk and to measure progress.
- Outline a comprehensive plan for maintaining security in the workplace, which includes establishing a liaison with law enforcement representatives and others who can help identify ways to prevent and mitigate workplace violence.
- Assign responsibility and authority for the program to individuals or teams with appropriate training and skills. The written plan should ensure that there are adequate resources available for this effort and that the team or responsible individuals develop expertise on workplace violence prevention in health care and social services.
- Affirm management commitment to a worker-supportive environment that places as much importance on employee safety and health as on serving the patient or client.
- Set up a company briefing as part of the initial effort to address such issues as preserving safety, supporting affected employees, and facilitating recovery.

Worksite Analysis

Worksite analysis involves a step-by-step, commonsense look at the workplace to find existing or potential hazards for workplace violence. This entails reviewing specific procedures or operations that contribute to hazards and specific locales where hazards may develop.

A "Threat Assessment Team," "Patient Assault Team," similar task force, or coordinator may assess the vulnerability to workplace violence and determine the appropriate preventive actions to be taken. Implementing the workplace violence prevention program then may be assigned to this group. The team should include representatives from senior management, operations, employee assistance, security, occupational safety and health, legal, and human resources staff.

The team or coordinator can review injury and illness records and workers' compensation claims to identify patterns of assaults that could be prevented by workplace adaptation, procedural changes, or employee training. As the team or coordinator identifies appropriate controls, these should be instituted.

The recommended program for worksite analysis includes, but is not limited to, analyzing and tracking records, monitoring trends and analyzing incidents, screening surveys, and analyzing workplace security.

[8] Section 11 (c)(1) of the OSH Act, which also applies to protected activity involving the hazard of workplace violence as it does for other health and safety matters: "No person shall discharge or in any manner discriminate against any employee because such employee has filed any complaint or instituted or caused to be instituted any proceeding under or related to this Act or has testified or is about to testify in any such proceeding or because of the exercise by such employee on behalf of himself or others of any right afforded by this Act."

Records Analysis and Tracking

This activity should include reviewing medical, safety, workers' compensation and insurance records—including the OSHA 200 log, if required—to pinpoint instances of workplace violence. Scan unit logs and employee and police reports of incidents or near-incidents of assaultive behavior to identify and analyze trends in assaults relative to particular departments, units, job titles, unit activities, work stations, and/or time of day. Tabulate these data to target the frequency and severity of incidents to establish a baseline for measuring improvement.

Monitoring Trends and Analyzing Incidents

Contacting similar local businesses, trade associations, and community and civic groups is one way to learn about their experiences with workplace violence and to help identify trends. Use several years of data, if possible, to trace trends of injuries and incidents of actual or potential workplace violence.

Screening Surveys

One important screening tool is to give employees a questionnaire or survey to get their ideas on the potential for violent incidents and to identify or confirm the need for improved security measures. Detailed baseline screening surveys can help pinpoint tasks that put employees at risk. Periodic surveys—conducted at least annually or whenever operations change or incidents of workplace violence occur—help identify new or previously unnoticed risk factors and deficiencies or failures in work practices, procedures, or controls. Also, the surveys help assess the effects of changes in the work processes (see Appendix A for a sample survey used in the State of Washington). The periodic review process should also include feedback and followup.

Independent reviewers, such as safety and health professionals, law enforcement or security specialists, insurance safety auditors, and other qualified persons may offer advice to strengthen programs. These experts also can provide fresh perspectives to improve a violence prevention program.

Workplace Security Analysis

The team or coordinator should periodically inspect the workplace and evaluate employee tasks to identify hazards, conditions, operations, and situations that could lead to violence.

To find areas requiring further evaluation, the team or coordinator should do the following:

- Analyze incidents, including the characteristics of assailants and victims, an account of what happened before and during the incident, and the relevant details of the situation and its outcome. When possible, obtain police reports and recommendations.
- Identify jobs or locations with the greatest risk of violence as well as processes and procedures that put employees at risk of assault, including how often and when.
- Note high-risk factors such as types of clients or patients (e.g., psychiatric conditions or patients disoriented by drugs, alcohol, or stress); physical risk factors of the building; isolated locations/job activities; lighting problems; lack of phones and other communication devices, areas of easy, unsecured access; and areas with previous security problems. (See sample checklist for assessing hazards in Appendix B.)
- Evaluate the effectiveness of existing security measures, including engineering control measures. Determine if risk factors have been reduced or eliminated, and take appropriate action.

Hazard Prevention and Control

After hazards of violence are identified through the systematic worksite analysis, the next step is to design measures through engineering or administrative and work practices to prevent or control these hazards. If violence does occur, post-incidence response can be an important tool in preventing future incidents.

Engineering Controls and Workplace Adaptation

Engineering controls, for example, remove the hazard from the workplace or create a barrier between the worker and the hazard. There are several measures that can effectively prevent or control workplace hazards, such as those actions presented in the following paragraphs. The selection of any measure, of course, should be based upon the hazards identified in the workplace security analysis of each facility.

- Assess any plans for new construction or physical changes to the facility or workplace to eliminate or reduce security hazards.
- Install and regularly maintain alarm systems and other security devices, panic buttons, hand-held alarms or noise devices, cellular phones, and private channel radios where risk is apparent or may be anticipated, and arrange for a reliable response system when an alarm is triggered.
- Provide metal detectors—installed or hand-held, where appropriate—to identify guns, knives, or other weapons, according to the recommendations of security consultants.

- Use a closed-circuit video recording for high-risk areas on a 24-hour basis. Public safety is a greater concern than privacy in these situations.
- Place curved mirrors at hallway intersections or concealed areas.
- Enclose nurses' stations, and install deep service counters or bullet-resistant, shatter-proof glass in reception areas, triage, admitting, or client service rooms.
- Provide employee "safe rooms" for use during emergencies.
- Establish "time-out" or seclusion areas with high ceilings without grids for patients acting out and establish separate rooms for criminal patients.
- Provide client or patient waiting rooms designed to maximize comfort and minimize stress.
- Ensure that counseling or patient care rooms have two exits.
- Limit access to staff counseling rooms and treatment rooms controlled by using locked doors.
- Arrange furniture to prevent entrapment of staff. In interview rooms or crisis treatment areas, furniture should be minimal, lightweight, without sharp corners or edges, and/or affixed to the floor. Limit the number of pictures, vases, ashtrays, or other items that can be used as weapons.
- Provide lockable and secure bathrooms for staff members separate from patient-client, and visitor facilities.
- Lock all unused doors to limit access, in accordance with local fire codes.
- Install bright, effective lighting indoors and outdoors.
- Replace burned-out lights, broken windows, and locks.
- Keep automobiles, if used in the field, well-maintained. Always lock automobiles.

Administrative and Work Practice Controls

Administrative and work practice controls affect the way jobs or tasks are performed. The following examples illustrate how changes in work practices and administrative procedures can help prevent violent incidents.

- State clearly to patients, clients, and employees that violence is not permitted or tolerated.
- Establish liaison with local police and state prosecutors. Report all incidents of violence. Provide police with physical layouts of facilities to expedite investigations.
- Require employees to report all assaults or threats to a supervisor or manager (e.g., can be confidential interview). Keep log books and reports of such incidents to help in determining any necessary actions to prevent further occurrences.
- Advise and assist employees, if needed, of company procedures for requesting police assistance or filing charges when assaulted.
- Provide management support during emergencies. Respond promptly to all complaints.
- Set up a trained response team to respond to emergencies.
- Use properly trained security officers, when necessary, to deal with aggressive behavior. Follow written security procedures.
- Ensure adequate and properly trained staff for restraining patients or clients.
- Provide sensitive and timely information to persons waiting in line or in waiting rooms. Adopt measures to decrease waiting time.
- Ensure adequate and qualified staff coverage at all times. Times of greatest risk occur during patient transfers, emergency responses, meal times, and at night. Locales with the greatest risk include admission units and crisis or acute care units. Other risks include admission of patients with a history of violent behavior or gang activity.
- Institute a sign-in procedure with passes for visitors, especially in a newborn nursery or pediatric department. Enforce visitor hours and procedures.
- Establish a list of "restricted visitors" for patients with a history of violence. Copies should be available at security checkpoints, nurses' stations, and visitor sign-in areas. Review and revise visitor check systems, when necessary. Limit information given to outsiders on hospitalized victims of violence.
- Supervise the movement of psychiatric clients and patients throughout the facility.
- Control access to facilities other than waiting rooms, particularly drug storage or pharmacy areas.
- Prohibit employees from working alone in emergency areas or walk-in clinics, particularly at night or when assistance is unavailable. Employees should never enter seclusion rooms alone.
- Establish policies and procedures for secured areas, and emergency evacuations, and for monitoring high-risk patients at night (e.g., open versus locked seclusion).
- Ascertain the behavioral history of new and transferred patients to learn about any past violent or assaultive behaviors. Establish a system—such as chart tags, log books, or verbal census reports—to

identify patients and clients with assaultive behavior problems, keeping in mind patient confidentiality and worker safety issues. Update as needed.

- Treat and/or interview aggressive or agitated clients in relatively open areas that still maintain privacy and confidentiality (e.g., rooms with removable partitions).
- Use case management conferences with co-workers and supervisors to discuss ways to effectively treat potentially violent patients.
- Prepare contingency plans to treat clients who are "acting out" or making verbal or physical attacks or threats. Consider using certified employee assistance professionals (CEAPs) or in-house social service or occupational health service staff to help diffuse patient or client anger.
- Transfer assaultive clients to "acute care units," "criminal units," or other more restrictive settings.
- Make sure that nurses and/or physicians are not alone when performing intimate physical examinations of patients.
- Discourage employees from wearing jewelry to help prevent possible strangulation in confrontational situations. Community workers should carry only required identification and money.
- Periodically survey the facility to remove tools or possessions left by visitors or maintenance staff which could be used inappropriately by patients.
- Provide staff with identification badges, preferably without last names, to readily verify employment.
- Discourage employees from carrying keys, pens, or other items that could be used as weapons.
- Provide staff members with security escorts to parking areas in evening or late hours. Parking areas should be highly visible, well-lighted, and safely accessible to the building.
- Use the "buddy system," especially when personal safety may be threatened. Encourage home health care providers, social service workers, and others to avoid threatening situations. Staff should exercise extra care in elevators, stairwells and unfamiliar residences; immediately leave premises if there is a hazardous situation; or request police escort if needed.
- Develop policies and procedures covering home health care providers, such as contracts on how visits will be conducted, the presence of others in the home during the visits, and the refusal to provide services in a clearly hazardous situation.
- Establish a daily work plan for field staff to keep a designated contact person informed about workers' whereabouts throughout the workday. If an employee does not report in, the contact person should followup.
- Conduct a comprehensive post-incident evaluation, including psychological as well as medical treatment, for employees who have been subjected to abusive behavior.

Post-Incident Response

Post-incident response and evaluation are essential to an effective violence prevention program. All workplace violence programs should provide comprehensive treatment for victimized employees and employees who may be traumatized by witnessing a workplace violence incident. Injured staff should receive prompt treatment and psychological evaluation whenever an assault takes place, regardless of severity. (See sample hospital policy in Appendix C). Transportation of the injured to medical care should be provided if care is not available on-site.

Victims of workplace violence suffer a variety of consequences in addition to their actual physical injuries. These include short and long-term psychological trauma, fear of returning to work, changes in relationships with co-workers and family, feelings of incompetence, guilt, powerlessness, and fear of criticism by supervisors or managers. Consequently, a strong followup program for these employees will not only help them to deal with these problems but also to help prepare them to confront or prevent future incidents of violence (Flannery, 1991, 1993; 1995).

There are several types of assistance that can be incorporated into the post-incident response. For example, trauma-crisis counseling, critical incident stress debriefing, or employee assistance programs may be provided to assist victims. Certified employee assistance professionals, psychologists, psychiatrists, clinical nurse specialists, or social workers could provide this counseling, or the employer can refer staff victims to an outside specialist. In addition, an employee counseling service, peer counseling, or support groups may be established.

In any case, counselors must be well trained and have a good understanding of the issues and consequences of assaults and other aggressive, violent behavior. Appropriate and promptly rendered post-incident debriefings and counseling reduce acute psychological trauma and general stress levels among victims and witnesses. In addition, such counseling educates staff about workplace violence and positively influences workplace and organizational cultural norms to reduce trauma associated with future incidents.

Training and Education

Training and education ensure that all staff are aware of potential security hazards and how to protect themselves and their co-workers through established policies and procedures.

All Employees

Every employee should understand the concept of "Universal Precautions for Violence," i.e., that violence should be expected but can be avoided or mitigated through preparation. Staff should be instructed to limit physical interventions in workplace altercations whenever possible, unless there are adequate numbers of staff or emergency response teams and security personnel available. Frequent training also can improve the likelihood of avoiding assault (Carmel and Hunter, 1990).

Employees who may face safety and security hazards should receive formal instruction on the specific hazards associated with the unit or job and facility. This includes information on the types of injuries or problems identified in the facility and the methods to control the specific hazards.

The training program should involve all employees, including supervisors and managers. New and reassigned employees should receive an initial orientation prior to being assigned their job duties. Visiting staff, such as physicians, should receive the same training as permanent staff. Qualified trainers should instruct at the comprehension level appropriate for the staff. Effective training programs should involve role playing, simulations, and drills.

Topics may include Management of Assaultive Behavior; Professional Assault Response Training; police assault avoidance programs, or personal safety training such as awareness, avoidance, and how to prevent assaults. A combination of training may be used depending on the severity of the risk.

Required training should be provided to employees annually. In large institutions, refresher programs may be needed more frequently (monthly or quarterly) to effectively reach and inform all employees.

The training should cover topics such as the following:

- The workplace violence prevention policy.
- Risk factors that cause or contribute to assaults.
- Early recognition of escalating behavior or recognition of warning signs or situations that may lead to assaults.
- Ways of preventing or diffusing volatile situations or aggressive behavior, managing anger, and appropriately using medications as chemical restraints.
- Information on multicultural diversity to develop sensitivity to racial and ethnic issues and differences.
- A standard response action plan for violent situations, including availability of assistance, response to alarm systems, and communication procedures.
- How to deal with hostile persons other than patients and clients, such as relatives and visitors.
- Progressive behavior control methods and safe methods of restraint application or escape.
- The location and operation of safety devices such as alarm systems, along with the required maintenance schedules and procedures.
- Ways to protect oneself and coworkers, including use of the "buddy system."
- Policies and procedures for reporting and recordkeeping.
- Policies and procedures for obtaining medical care, counseling, workers' compensation, or legal assistance after a violent episode or injury.

Supervisors, Managers, and Security Personnel

Supervisors and managers should ensure that employees are not placed in assignments that compromise safety and should encourage employees to report incidents. Employees and supervisors should be trained to behave compassionately towards coworkers when an incident occurs.

They should learn how to reduce security hazards and ensure that employees receive appropriate training. Following training, supervisors and managers should be able to recognize a potentially hazardous situation and to make any necessary changes in the physical plant, patient care treatment program, and staffing policy and procedures to reduce or eliminate the hazards.

Security personnel need specific training from the hospital or clinic, including the psychological components of handling aggressive and abusive clients, types of disorders, and ways to handle aggression and defuse hostile situations.

The training program should also include an evaluation. The content, methods, and frequency of training should be reviewed and evaluated annually by the team or coordinator responsible for implementation. Program evaluation may involve supervisor and/or employee interviews, testing and observing, and/or reviewing reports of behavior of individuals in threatening situations.

Recordkeeping and Evaluation of the Program

Recordkeeping and evaluation of the violence prevention program are necessary to determine overall effectiveness and identify any deficiencies or changes that should be made.

Recordkeeping

Recordkeeping is essential to the success of a workplace violence prevention program. Good records help employers determine the severity of the problem, evaluate methods of hazard control, and identify training needs. Records can be especially useful to large organizations and for members of a business group or trade association who "pool" data. Records of injuries, illnesses, accidents, assaults, hazards, corrective actions, patient histories, and training, among others, can help identify problems and solutions for an effective program.

The following records are important:

- OSHA Log of Injury and Illness (OSHA 200). OSHA regulations require entry on the Injury and Illness Log of any injury that requires more than first aid, is a lost-time injury, requires modified duty, or causes loss of consciousness.[9] (This applies only to establishments required to keep OSHA logs.) Injuries caused by assaults, which are otherwise recordable, also must be entered on the log. A fatality or catastrophe that results in the hospitalization of 3 or more employees must be **reported to OSHA within 8 hours**. This includes those resulting from workplace violence and applies to **all** establishments.
- Medical reports of work injury and supervisors' reports for each recorded assault should be kept. These records should describe the type of assault, i.e., unprovoked sudden attack or patient-to-patient altercation; who was assaulted; and all other circumstances of the incident. The records should include a description of the environment or location, potential or actual cost, lost time, and the nature of injuries sustained.
- Incidents of abuse, verbal attacks or aggressive behavior—which may be threatening to the worker but do not result in injury, such as pushing or shouting and acts of aggression towards other clients—should be recorded, perhaps as part of an assaultive incident report. These reports should be evaluated routinely by the affected department. (See sample incident forms in Appendix D).
- Information on patients with a history of past violence, drug abuse, or criminal activity should be recorded on the patient's chart. All staff who care for a potentially aggressive, abusive, or violent client should be aware of their background and history. Admission of violent clients should be logged to help determine potential risks.
- Minutes of safety meetings, records of hazard analyses, and corrective actions recommended and taken should be documented.
- Records of all training programs, attendees, and qualifications of trainers should be maintained.

Evaluation

As part of their overall program, employers should evaluate their safety and security measures. Top management should review the program regularly, and with each incident, to evaluate program success. Responsible parties (managers, supervisors, and employees) should collectively reevaluate policies and procedures on a regular basis. Deficiencies should be identified and corrective action taken.

An evaluation program should involve the following:

- Establishing a uniform violence reporting system and regular review of reports.
- Reviewing reports and minutes from staff meetings on safety and security issues.
- Analyzing trends and rates in illness/injury or fatalities caused by violence relative to initial or "baseline" rates.
- Measuring improvement based on lowering the frequency and severity of workplace violence.
- Keeping up-to-date records of administrative and work practice changes to prevent workplace violence to evaluate their effectiveness.
- Surveying employees before and after making job or worksite changes or installing security measures or new systems to determine their effectiveness.
- Keeping abreast of new strategies available to deal with violence in the health care and social service fields as these develop.
- Surveying employees who experience hostile situations about the medical treatment they received initially and, again, several weeks afterward, and then several months later.

[9] The Occupational Safety and Health Act and recordkeeping regulations in *Title 29 Code of Federal Regulations (CFR), Part 1904* provide specific recording requirements that comprise the framework of the occupational safety and health recording system (BLS, 1986a). BLS has issued guidelines that provide official Agency interpretations concerning the recordkeeping and reporting of occupational injuries and illnesses (BLS, 1986b).

- Complying with OSHA and state requirements for recording and reporting deaths, injuries, and illnesses.
- Requesting periodic law enforcement or outside consultant review of the worksite for recommendations on improving employee safety.

Management should share workplace violence prevention program evaluation reports with all employees. Any changes in the program should be discussed at regular meetings of the safety committee, union representatives, or other employee groups.

Sources of Assistance

Employers who would like assistance in implementing an appropriate workplace violence prevention program can turn to the OSHA Consultation service provided in their state. Primarily targeted at smaller companies, the consultation service is provided at no charge to the employer and is independent of OSHA's enforcement activity. (See Appendix E.)

OSHA's efforts to assist employers combat workplace violence are complemented by those of NIOSH (1-800-35-NIOSH) and public safety officials, trade associations, unions, insurers, human resource, and employee assistance professionals as well as other interested groups. Employers and employees may contact these groups for additional advice and information.

Conclusion

OSHA recognizes the importance of effective safety and health program management in providing safe and healthful workplaces. In fact, OSHA's consultation services help employers establish and maintain safe and healthful workplaces, and the agency's Voluntary Protection Programs were specifically established to recognize worksites with exemplary safety and health programs. (See Appendix E.) Effective safety and health programs are known to improve both morale and productivity and reduce workers' compensation costs.

OSHA's violence prevention guidelines are an essential component to workplace safety and health programs. OSHA believes that the performance-oriented approach of the guidelines provides employers with flexibility in their efforts to maintain safe and healthful working conditions.

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Appendix A: SHARP Staff Assault Study (Staff Survey)

The following items serve merely as an example of what might be used or modified by employers in these industries to help prevent workplace violence.

ID Number _____

I. Priorities

A number of factors may be important in preventing assaults, or reducing the impact of assaults. We would like to know your views on what the most important factors are. For these questions, please use the following definition of assault: "Physical contact that results in injury." (Injury may be major or minor; e.g., mild soreness, scratches, or bruises would be included.)

1. What do you think is the most important factor contributing to assaults on staff at Eastern and Western State Hospitals? _____

2. A number of factors have been suggested as possibly important in determining whether assaults occur, or the impact of assaults. Please indicate which factors you think are most important. Please indicate only your top five priorities. In other words, many of the following areas may be important, but we are interested in which are **most** important. Please place a "1" next to the issue that you think is the top priority, and a "2" next to the issue that you think is the next highest priority, and so forth. If you have no opinion or don't know, please check "Don't know."

   _____ a. Staff training in self-defense/restraint procedures
   _____ b. Staff clinical and interpersonal skills
   _____ c. Staff fitness
   _____ d. An effective security alarm system
   _____ e. Adequate numbers of personnel
   _____ f. Hospital practices (e.g., handling patients' money)
   _____ g. Physical environment (e.g., noise)
   _____ h. Identifying patients with a history of assaults
   _____ i. Identifying patients with potentially assaultive (e.g., agitated) behavior
   _____ j. Transfer of information at shift change about potentially assaultive patients
   _____ k. Procedures for transporting patients
   _____ l. Procedures for reporting assaults to administrators
   _____ m. Procedures for evaluating staff who have been involved in assaults
   _____ n. Procedures for reporting assaults to police
   _____ o. Legal penalties for competent assaultive patients
   _____ p. Structured psychological support for assaulted staff
   _____ q. Timeliness of L&I processing of Worker's Compensation claims
   _____ r. Fairness of L&I processing of Worker's Compensation claims
   _____ s. Timeliness of DSHS processing of Assault Pay claims
   _____ t. Fairness of DSHS processing of Assault Pay claims
   _____ u. Other _____
   _____ v. Don't know

ID Number _____

3. In which of the following areas do you think it is most important to make improvements at your hospital? Again, please indicate your top five priorities by placing a "1" next to the area you think is most important, a "2" next to the area you think is next most important, and so forth. If you have no opinion or don't know, please check "Don't know."

   _____ a. Staff training in self-defense/restraint procedures
   _____ b. Staff clinical and interpersonal skills
   _____ c. Staff fitness
   _____ d. An effective security alarm system
   _____ e. Adequate numbers of personnel
   _____ f. Hospital practices (e.g., handling patients' money)
   _____ g. Physical environment (e.g., noise)
   _____ h. Identifying patients with a history of assaultive behavior
   _____ i. Identifying patients with potentially assaultive (e.g., agitated) behavior
   _____ j. Transfer of information at shift change about potentially assaultive patients
   _____ k. Procedures for transporting patients
   _____ l. Procedures for reporting assaults to administrators
   _____ m. Procedures for evaluating staff who have been involved in assaults
   _____ n. Procedures for reporting assaults to police
   _____ o. Legal penalties for competent assaultive patients
   _____ p. Structured psychological support for assaulted staff
   _____ q. Timeliness of L&I processing of Worker's Compensation claims
   _____ r. Fairness of L&I processing of Worker's Compensation claims
   _____ s. Timeliness of DSHS processing of Assault Pay claims
   _____ t. Fairness of DSHS processing of Assault Pay claims
   _____ u. Other _____
   _____ v. Don't know

4. Comments: _____

ID Number _____

II. Training

5. Please indicate below which of the following types of training you have received during your employment at Eastern/Western. Also, for each type of training you have received, please indicate (on the scale of 1 - 5) how helpful that training was to you.

		not at all helpful				very helpful	don't know
a. Initial Training/Orientation	received	1	2	3	4	5	
• Interpersonal communication	☐ Yes ☐ No	☐	☐	☐	☐	☐	☐
• Assessing potential assaultiveness	☐ Yes ☐ No	☐	☐	☐	☐	☐	☐
• Verbal de-escalation	☐ Yes ☐ No	☐	☐	☐	☐	☐	☐
• Self-defense	☐ Yes ☐ No	☐	☐	☐	☐	☐	☐
• Containment/restraint procedures	☐ Yes ☐ No	☐	☐	☐	☐	☐	☐

		not at all helpful				very helpful	don't know
b. Formal Training Updates	received	1	2	3	4	5	
• Interpersonal communication	☐ Yes ☐ No	☐	☐	☐	☐	☐	☐
• Assessing potential assaultiveness	☐ Yes ☐ No	☐	☐	☐	☐	☐	☐
• Verbal de-escalation	☐ Yes ☐ No	☐	☐	☐	☐	☐	☐
• Self-defense	☐ Yes ☐ No	☐	☐	☐	☐	☐	☐
• Containment/restraint procedures	☐ Yes ☐ No	☐	☐	☐	☐	☐	☐

		not at all helpful				very helpful	don't know
c. Informal (on-the-job) training	received	1	2	3	4	5	
• Interpersonal communication	☐ Yes ☐ No	☐	☐	☐	☐	☐	☐
• Assessing potential assaultiveness	☐ Yes ☐ No	☐	☐	☐	☐	☐	☐
• Verbal de-escalation	☐ Yes ☐ No	☐	☐	☐	☐	☐	☐
• Self-defense	☐ Yes ☐ No	☐	☐	☐	☐	☐	☐
• Containment/restraint procedures	☐ Yes ☐ No	☐	☐	☐	☐	☐	☐

6. When was your most recent formal training in the management of assaultive patients?

   Please list month and year: _____

7. Comments: _____

ID Number _____

III. Staffing

8. Please indicate how important you think it is to make improvements at your hospital in the following areas:

	not at all important				very important
	1	2	3	4	5
a. Adequate numbers of licensed nursing personnel (RNs & LPNs)	☐	☐	☐	☐	☐
b. Adequate numbers of mental health technicians (MHTs & PSAs)	☐	☐	☐	☐	☐
c. Adequate numbers of physicians	☐	☐	☐	☐	☐
d. Adequate numbers of staff for afternoon & night shifts	☐	☐	☐	☐	☐

9. Comments: _____

_____

_____

IV. Alarm Security Systems

10. In your opinion, what are the most important features of a security alarm system (an alarm system for calling for help in the event of an assault?) In other words, many of the features listed below may be very important. Please indicate the five most important features by placing a "1" next to the feature that you think is most important, and a "2" next to the feature that you think is the next most important, etc. If you have no opinion or don't know, check "Don't know."

_____ a. Convenient to carry with you
_____ b. Works both indoors and outdoors
_____ c. Easy to activate
_____ d. Sounds audible alarm
_____ e. Don't know
_____ f. In a room accessible only to staff (e.g., nursing station)
_____ g. Identifies your location
_____ h. Brings immediate response
_____ i. Operates reliably
_____ j. Other

11. Comments: _____

_____

_____

V. Health and Safety Committee

12. Do you know what role the joint labor-management Health and Safety Committee plays at your hospital, in general? Yes ☐ No ☐

13. Do you know what role the joint labor-management Health and Safety Committee plays at your hospital, specifically with regard to staff assaults? Yes ☐ No ☐

14. Do you know the name of at least one labor representative on the Health and Safety Committee? Yes ☐ No ☐

15. Comments: _____

_____

_____

ID Number _____

VI. Hospital Practices

16. In your opinion, which of the following practices are most likely to contribute to staff/patient disagreements of the type that may lead to assaults? Please indicate the five most important practices by placing a "1" next to the practice that you think is most likely to contribute to assaults, and a "2" next to the practice you think is next most likely to contribute to assaults, etc. If you have no opinion or don't know, check "Don't know."

Practices for handling:

_____ a. Patients' money
_____ b. Patients' sexual behavior
_____ c. Visits with clinical staff
_____ d. Seclusion and restraint
_____ e. Visits from outside hospital
_____ f. Patients' daytime access to own bedrooms
_____ g. Smoking
_____ h. Privacy
_____ Don't know
_____ i. Medication
_____ j. Programming (activities scheduled)
_____ k. Scheduling activities (e.g., flexibility)
_____ l. Transfers between wards
_____ m. Dates of discharge
_____ n. Access to outdoors/exercise
_____ o. Providing information about rules
_____ p. Diagnostic interviews
_____ q. Other

17. Comments: _____

_____

_____

_____

VII. Physical Environment

18. In your opinion, which of the following aspects of the physical environment are most likely to contribute to assaults? Please indicate the five most important aspects by placing a "1" next to the aspect of the environment that you think is most likely to contribute to assaults, and a "2" next to the aspect you think is next most likely to contribute to assaults, etc. If you have no opinion or don't know, check "Don't know."

_____ a. Noise levels
_____ b. Temperature levels
_____ c. Food
_____ d. Lighting
_____ Don't know
_____ e. Overcrowding
_____ f. Cleanliness
_____ g. Privacy
_____ h. Other

19. Comments: _____

_____

_____

_____

ID Number _____

VIII. Dangerous Situations

20. Please indicate whether any of the following situations have happened to you.

a. Only employee on ward

Has this ever happened? Yes ☐ No ☐

Does it happen frequently? Yes ☐ No ☐

b. Not within hearing of other employees

Has this ever happened? Yes ☐ No ☐

Does it happen frequently? Yes ☐ No ☐

c. Not within sight of other employees

Has this ever happened? Yes ☐ No ☐

Does it happen frequently? Yes ☐ No ☐

21. Comments: _____

_____

_____

_____

_____

_____

_____

IX. Job Satisfaction

22. All in all, how satisfied are you with your job?
☐ Not at all satisfied
☐ Not too satisfied
☐ Somewhat satisfied
☐ Very satisfied

23. How strongly would you recommend your job to someone else?
☐ Not at all strongly
☐ Not too strongly
☐ Somewhat strongly
☐ Very strongly

24. If you were looking for a job now, how likely is it that you would decide to take this job again?
☐ Not at all likely
☐ Not too likely
☐ Somewhat likely
☐ Very likely

ID Number _____

25. To what extent is your supervisor willing to listen to your work-related problems?
    - ☐ Not at all willing
    - ☐ Slightly willing
    - ☐ Somewhat willing
    - ☐ Very willing

How satisfied are you with:	not at all satisfied	not too satisfied	somewhat satisfied	very satisfied
	1	2	3	4
26. The way supervisors treat workers?	☐	☐	☐	☐
27. The way work policies are put into practice?	☐	☐	☐	☐
28. The competence of your supervisors?	☐	☐	☐	☐
29. The praise you get for doing a good job?	☐	☐	☐	☐
30. How satisfied are you that you can turn to fellow workers for help when something is troubling you?	☐	☐	☐	☐
31. How satisfied are you with the way your fellow workers respond to your emotions, such as anger, sorrow or laughter?	☐	☐	☐	☐
32. How satisfied are you that your fellow workers accept and support your new ideas or thoughts?	☐	☐	☐	☐

33. How often are you physically exhausted after work?
    - ☐ Never
    - ☐ Seldom
    - ☐ Often
    - ☐ Always

34. How often are you mentally exhausted after work?
    - ☐ Never
    - ☐ Seldom
    - ☐ Often
    - ☐ Always

ID Number _____

35. Overall, how would you rate your health at the present time?
    - ☐ Poor
    - ☐ Fair
    - ☐ Good
    - ☐ Very Good
    - ☐ Excellent

36. How would you rate your health compared to other persons your age?
    - ☐ Poor
    - ☐ Fair
    - ☐ Good
    - ☐ Very Good
    - ☐ Excellent

X. Assault Experiences

37. Patients may be aggressive toward staff in a number of ways, some more serious than others. We are interested in how many times you personally have experienced each of the following forms of aggression by patients at your hospital. Please indicate the number of times you have experienced each form of aggression, within the last year or ever. Please use the following rating scale:

    0 = never 1 = once 2 = 2 - 5 times 3 = more than five times

    Within the past 12 months:

    _____ a. threat of assault but no physical contact
    _____ b. physical contact but no physical injury
    _____ c. mild soreness/surface abrasion/scratches/small bruises
    _____ d. major soreness/cuts/large bruises
    _____ e. severe laceration/fracture/head injury
    _____ f. loss of limb/permanent physical disability

    During your employment at this hospital:

    _____ a. threat of assault but no physical contact
    _____ b. physical contact but no physical injury
    _____ c. mild soreness/surface abrasion/scratches/small bruises
    _____ d. major soreness/cuts/large bruises
    _____ e. severe laceration/fracture/head injury
    _____ f. loss of limb/permanent physical disability

ID Number _____

38. If you have been assaulted, please answer the following questions. (If you have been assaulted more than once, please consider the most recent assault.)

    a. When did the assault occur? (Please provide the approximate date) _____

    b. What happened? Please describe the assault briefly (who assaulted you, what triggered the assault, what they did, whether they used a weapon, what happened after the assault.)

    _____

    _____

    _____

    _____

    _____

    _____

    c. What could have prevented the assault or reduced your injuries?

    _____

    _____

    _____

    d. Did you call for help in some way? Please describe. Did help arrive quickly?

    _____

    _____

    _____

    e. Were you able to apply the training you had received? Please describe. If not, why not?

    _____

    _____

    _____

    f. Please indicate whether you did each of the following:

    Report the incident on daily ward report? Yes ☐ No ☐

    If you didn't report the incident, why not?

    _____

    Report the incident on an Incident Report? Yes ☐ No ☐

    If you didn't report the incident, why not?

    _____

ID Number _____

g. As you may know, Industrial Insurance (Workers' Compensation) claims are handled by the Dept. of Labor & Industries, and Assault Pay claims are handled by the Dept. of Social & Health Services. Please indicate what your experiences were regarding this assault.

1. Did you apply for Workers' Compensation benefits from L&I? Yes ☐ No ☐
2. If yes, how satisfied were you with the service you received from L&I regarding your claim?

	not at all satisfied 1	2	3	4	very satisfied 5	don't know
Timeliness	☐	☐	☐	☐	☐	☐
Fairness	☐	☐	☐	☐	☐	☐

3. Did you apply for Assault Pay from DSHS? Yes ☐ No ☐
4. If yes, how satisfied were you with the service you received from DSHS regarding your claim?

	not at all satisfied 1	2	3	4	very satisfied 5	don't know
Timeliness	☐	☐	☐	☐	☐	☐
Fairness	☐	☐	☐	☐	☐	☐

h. Comments: _____

_____

_____

XI. Respondent Information

39. What is your job classification?

40. In which area do you work?

☐ Adult psychiatric (APU) ☐ Geriatric (GPU)

☐ Legal offenders (LOU) ☐ Other

41. How long have you worked at Eastern/Western? _____ years _____ months

XII. Comments

42. Are there other issues that you think are important? If so, please describe (feel free to use the back of this sheet as well.)

_____

_____

_____

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Appendix B: Workplace Violence Checklist

The following items serve merely as an example of what might be used or modified by employers in these industries to help prevent workplace violence.

This checklist helps identify present or potential workplace violence problems. Employers also may be aware of other serious hazards not listed here.

Designated competent and responsible observers can readily make periodic inspections to identify and evaluate workplace security hazards and threats of workplace violence. These inspections should be scheduled on a regular basis; when new, previously unidentified security hazards are recognized; when occupational deaths, injuries, or threats of injury occur; when a safety, health and security program is established; and whenever workplace security conditions warrant an inspection.

Periodic inspections for security hazards include identifying and evaluating potential workplace security hazards and changes in employee work practices which may lead to compromising security. Please use the following checklist to identify and evaluate workplace security hazards. **TRUE notations indicate a potential risk for serious security hazards:**

_____ T _____ F	This industry frequently confronts violent behavior and assaults of staff.
_____ T _____ F	Violence occurs regularly where this facility is located.
_____ T _____ F	Violence has occurred on the premises or in conducting business.
_____ T _____ F	Customers, clients, or coworkers assault, threaten, yell, push, or verbally abuse employees or use racial or sexual remarks.
_____ T _____ F	Employees are **NOT** required to report incidents or threats of violence, regardless of injury or severity, to employer.
_____ T _____ F	Employees have **NOT** been trained by the employer to recognize and handle threatening, aggressive, or violent behavior.
_____ T _____ F	Violence is accepted as "part of the job" by some managers, supervisors, and/or employees.
_____ T _____ F	Access and freedom of movement within the workplace are **NOT** restricted to those persons who have a legitimate reason for being there.
_____ T _____ F	The workplace security system is inadequate—i.e., door locks malfunction, windows are not secure, and there are no physical barriers or containment systems.
_____ T _____ F	Employees or staff members have been assaulted, threatened, or verbally abused by clients and patients.
_____ T _____ F	Medical and counseling services have **NOT** been offered to employees who have been assaulted.
_____ T _____ F	Alarm systems such as panic alarm buttons, silent alarms, or personal electronic alarm systems are **NOT** being used for prompt security assistance.
_____ T _____ F	There is no regular training provided on correct response to alarm sounding.
_____ T _____ F	Alarm systems are **NOT** tested on a monthly basis to assure correct function.
_____ T _____ F	Security guards are **NOT** employed at the workplace.
_____ T _____ F	Closed circuit cameras and mirrors are **NOT** used to monitor dangerous areas.
_____ T _____ F	Metal detectors are **NOT** available or **NOT** used in the facility.
_____ T _____ F	Employees have **NOT** been trained to recognize and control hostile and escalating aggressive behaviors, and to manage assaultive behavior.
_____ T _____ F	Employees **CANNOT** adjust work schedules to use the "Buddy system" for visits to clients in areas where they feel threatened.
_____ T _____ F	Cellular phones or other communication devices are **NOT** made available to field staff to enable them to request aid.
_____ T _____ F	Vehicles are **NOT** maintained on a regular basis to ensure reliability and safety.
_____ T _____ F	Employees work where assistance is **NOT** quickly available.

Appendix C: Assaulted and/or Battered Employee Policy

Hospital Memorandum
#118.13, June 30, 1994

The following items serve merely as an example of what might be used or modified by employers in these industries to help prevent workplace violence.

I. Purpose:

To establish a formalized procedure to ensure that resources are available to provide support to all hospital employees who have recently been assaulted and/or battered.

II. Policy:

Each employee who is assaulted and/or battered will have access to treatment and services to manage the trauma.

III. Implementation:

A. *Definition:*

Assaulted employee: Any employee who is reasonably put in fear of being imminently struck by a patient, either by a menacing gesture, sudden move alone, or accompanied by a threat.

Battered employee: Any employee who experiences actual physical contact from another (whether or not a physical injury occurred).

B. *Procedure:*

1. Assaulted Employee:
   a. Following an assault, the employee must notify his/her immediate supervisor. The supervisor must complete VA Form 10-2633 on all patient-on-staff assaults.

   b. The Supervisor should refer the employee to the Employee Assistance Program. Timely referral, via electronic mail, is encouraged.

   c. A member of the Employee Assistance Program staff will make contact with the employee to assist the employee with the services needed which may include: counseling, legal advice, information regarding workmens' compensation/medical insurance.

   d. Following an assault, a community meeting must take place on the unit where the assault occurred, including patients and staff to process the incident as soon as possible.

2. *Battered Employee:*
   a. Following an incident whereby an employee is battered, the employee must notify his/her immediate supervisor.

   b. At the time of the incident, a CA-1 form and VA form 2162 must be completed. If the employee is unable to do so, it must be completed by the supervisor. The supervisor must also complete VA Form 10-2633 on all patient-on-staff assaults.

   c. The battered employee must report to Employee Health for evaluation and treatment of injuries. If the battery occurs on non-administrative duty hours, the employee should report to admissions to be evaluated by the O.D.

   d. Following evaluation and treatment of injuries by Employee Health, the individual is referred by the Employee Health Practitioner to the Employee Assistance Program. Timely referral, via electronic mail, is encouraged.

   e. The Employee Assistance Program initiates contact with the battered employee and

      1. Informs employee of the service available.
      2. Assists employees in attaining these services such as: counseling, legal advice via police service, workmens' compensation and medical benefits via Personnel Service, etc.

   f. If a battered employee determines on his or her own to file an application for criminal prosecution with the Concord District Court, the treating psychiatrist may accompany the employee to court without need for legal process either to an informal hearing before a clerk-magistrate or a hearing before a judge. The physician

may testify to facts known to him. He may not bring VA patient records unless a court orders them to be produced. The physician may, if asked by the court, offer an opinion regarding the competence or capacity of the patient to understand the nature of his actions or to understand the nature of the court's proceedings. The VA psychiatrist may not agree to undertake an evaluation of the patient in order to report back to the court. These duties may be performed by the court psychiatrist or, in the case of a period of hospitalization for evaluation, a state hospital. A court order or a request for the presentation of a medical record to the court must be referred to Medical Administration for Processing.

IV. References:

Hospital Memorandum, 003.07, Patient Injury Control, Preparation of VA Form 10-2633, Report of Special Incident Involving a Beneficiary.

Hospital Memorandum #05.18, "Employee Assistance Program."

V. Rescissions:

Hospital Memorandum #118.13, May 14, 1991.

Source: Reprinted with permission of Marilyn Lewis Lanza, D.N.Sc., A.R.N.P., C.S.; Judith Keefe, R.N.; and Margaret Henderson, R.N., M.Ed., Edith Nourse Rogers Memorial Veterans Hospital, Bedford, MA.

Appendix D: Violence Incident Report Forms SAMPLE

The following items serve merely as an example of what might be used or modified by employers in these industries to help prevent workplace violence.

(Sample/Draft - Adapt to your own location and business circumstances)

Confidential Incident Report

To: _____ Date of Incident: _____

Location of Incident: _____

_____
Map/sketch on reverse side or attached

From: _____ Phone: _____ Time of Incident: _____

Nature of the incident: (xx all applicable boxes)

_____ Assaults or violent acts: _____ Type "1" _____ Type "2" _____ Type "3" _____ Other
_____ Preventative or warning report
_____ Bomb or terrorist type threat (special checklists attached ☐ Yes ☐ No)
_____ Transportation accident
_____ Contacts with objects or equipment
_____ Falls
_____ Exposures
_____ Fires or explosions
_____ Other

Legal counsel advised of incident ☐ Yes ☐ No EAP advised ☐ Yes ☐ No
Warning or preventative measures ☐ Yes ☐ No
Number of persons affected _____
(For each person complete a report; however, to the extent facts are duplicative, any person's report may incorporate another person's report.)
Name of affected person(s) _____ Service date _____
Position: _____ member of labor organization ☐ Yes ☐ No
Supervisor: _____ has supervisor been notified ☐ Yes ☐ No
Family: _____ has been notified by _____ ☐ Yes ☐ No

Lost work time ☐ Yes ☐ No
Anticipated return to work _____
Third parties or non-employee involvement ☐ Yes ☐ No (include contractor and lease employees, visitors, vendors, customers)

Nature of the incident

Briefly describe: (1) event(s); (2) witnesses with addresses and status included; (3) location details; (4) equipment/weapon details; (5) weather; (6) other records of the incident (e.g., police report, recordings, videos); (7) the ability to observe and reliability of witnesses; (8) were the parties possibly impaired because of illness, injury, drugs or alcohol (were tests taken to verify same ☐ Yes ☐ No); (9) parties notified internally (employee relations, medical, legal, operations, etc.) and externally (police, fire, ambulance, EAP, family, etc.)

Previous or related incidents of this type ☐ Yes ☐ No or by this person ☐ Yes ☐ No
Preventative steps ☐ Yes ☐ No OSHA log or other OSHA action required ☐ Yes ☐ No

Incident Response Team: _____

_____

_____

Team Leader _____ _____
Signature Date

Source: Reprinted with permission of Karen Smith Keinbaum, Esq., Counsel to the Law Firm of Abbott, Nicholson, Quilter, Esshaki & Youngblood, P.C., Detroit, MI

Violence Incident Report Forms **SAMPLE**

The following items serve merely as an example of what might be used or modified by employers in these industries to help prevent workplace violence.

A reportable violent incident should be defined as any threatening remark or overt act of physical violence against a person(s) or property whether reported or observed.

1. Date: _____
   Day of week: _____
   Time: _____
   Assailant: Female_____ Male_____

2. Specific Location:

3. Violence directed towards: _____ Patient _____ Staff _____ Visitor _____ Other
   Assailant: _____ Patient _____ Staff _____ Visitor _____ Other
   Assailant's Name: _____
   Assailant: _____ Unarmed _____ Armed (weapon) _____

4. Predisposing factors:
   _____ Intoxication
   _____ Grief reaction
   _____ Gang related
   _____ Other (Describe) _____
   _____ Dissatisfied with care/waiting time
   _____ Prior history of violence

5. Description of incident:
   _____ Physical abuse
   _____ Verbal abuse
   _____ Other

6. Injuries:
   _____ Yes
   _____ No

7. Extent of Injuries:

8. Detailed description of the incident:

9. Did any person leave the area because of incident?
   _____ Yes _____ No _____ Unable to determine

10. Present at time of incident:
    _____ Police _____ Name of department
    _____ Hospital security officer

11. Needed to call:
    _____ Police _____ Department
    _____ Hospital security

12. Termination of incident:
    Incident diffused _____ Yes _____ No
    Police notified _____ Yes _____ No
    Assailant arrested _____ Yes _____ No

13. Disposition of assailant:
    Stayed on premises _____
    Escorted off premises _____
    Left on own _____
    Other _____

14. Restraints used: _____ Yes _____ No
    Type: _____

15. Report completed by: _____ Title: _____
    Witnesses: _____
    Supervisor notified: _____ Time: _____

Please put additional comments, according to numbered section, on reverse side of form.

Source: Reprinted with permission of the Metropolitan Chicago Healthcare Council, *Guidelines for Dealing with Violence in Health Care,* Chicago, IL, 1995.

Appendix E: Sources of OSHA Assistance

Safety and Health Management

Effective management of worker safety and health protection is a decisive factor in reducing the extent and severity of work-related injuries and illnesses and their related costs. To assist employers and employees in developing effective safety and health programs, OSHA published recommended *Safety and Health Program Management Guidelines* (*Fed Reg* 54(18):3908-3916, January 26, 1989). These voluntary guidelines apply to all places of employment covered by OSHA.

The guidelines identify four general elements that are critical to the development of a successful safety and health management program:

- management commitment and employee involvement,
- worksite analysis,
- hazard prevention and control, and
- safety and health training.

The guidelines recommend specific actions under each of these general elements to achieve an effective safety and health program. A single free copy of the guidelines can be obtained from the OSHA Publications Office, U.S. Department of Labor, P.O. Box 37535, Washington, DC 20213-7535, by sending a self-addressed mailing label with your request.

State Programs

The *Occupational Safety and Health Act of 1970* encourages states to develop and operate their own job safety and health plans. States with plans approved under section 18(b) of the Act must adopt standards and enforce requirements that are at least as effective as federal requirements. There are currently 25 state plan states: 23 of these states administer plans covering both private and public (state and local government) employees; the other 2 states, Connecticut and New York, cover public employees only. Plan states must adopt standards comparable to federal requirements within 6 months of a federal standard's promulgation. Until such time as a state standard is promulgated, federal OSHA provides interim enforcement assistance, as appropriate, in these states.

Consultation Services

Consultation assistance is available on request to employers who want help in establishing and maintaining a safe and healthful workplace. Largely funded by OSHA, the service is provided at no cost to the employer. Primarily developed for smaller employers with more hazardous operations, the consultation service is delivered by state government agencies or universities employing professional safety consultants and health consultants. Comprehensive assistance includes an appraisal of all mechanical physical work practices, and environmental hazards of the workplace and all aspects of the employer's present job safety and health program.

The program is separate from OSHA's inspection efforts. No penalties are proposed or citations issued for any safety or health problems identified by the consultant. The service is confidential.

For more information concerning consultation assistance, see the list of consultation projects elsewhere in this appendix.

Voluntary Protection Programs

Voluntary Protection Programs and onsite consultation services, when coupled with an effective enforcement program, expand worker protection to help meet the goals of the OSH Act. The three VPPs—Star, Merit, and Demonstration—are designed to recognize outstanding achievement by companies that have successfully incorporated comprehensive safety and health programs into their total management system. They motivate others to achieve excellent safety and health results in the same outstanding way as they establish a cooperative relationship between employers, employees, and OSHA.

For additional information on VPPs and how to apply, contact OSHA's area or regional offices.

Training and Education

OSHA's area offices offer a variety of informational services, such as publications, audiovisual aids, technical advice, and speakers for special engagements. OSHA's Training Institute in Des Plaines, IL, provides basic and advanced courses in safety and health for federal and state compliance officers, state consultants, federal agency personnel, and private sector employers, employees, and their representatives.

OSHA also provides funds to nonprofit organizations, through grants, to conduct workplace training an education in subjects where OSHA believes there is a lack of workplace training. Grants are awarded annually and grant recipients are expected to contribute 20 percent of the total grant cost.

For more information on grants, training, and education, contact the OSHA Training Institute, Office of Training and Education, 1555 Times Drive, Des Plaines, IL 60018, (847) 297-4810.

For further information on any OSHA program, contact your nearest OSHA area or regional office.

States with Approved Plans

Commissioner
Alaska Department of Labor
1111 West 8th Street
Room 306
Juneau, AK 99801
(907) 465-2700

Director
Industrial Commission of Arizona
800 W. Washington
Phoenix, AZ 85007
(602) 542-5795

Director
California Department of Industrial Relations
45 Fremont Street
San Francisco, CA 94105
(415) 972-8835

Director
Connecticut Department of Labor
Division of Occupational Safety and Health
200 Folly Brook Boulevard
Wethersfield, CT 06109
(203) 566-5123

Director
Hawaii Department of Labor and Industrial Relations
830 Punchbowl Street
Honolulu, HI 96813
(808) 586-8844

Commissioner
Indiana Department of Labor
State Office Building
402 West Washington Street
Room W195
Indianapolis, IN 46204
(317) 232-2378

Commissioner
Iowa Division of Labor Services
1000 E. Grand Avenue
Des Moines, IA 50319
(515) 281-3447

Secretary
Kentucky Labor Cabinet
1049 U.S. Highway, 127 South
Frankfort, KY 40601
(502) 564-3070

Commissioner
Maryland Division of Labor and Industry
Department of Licensing and Regulation
501 St. Paul Place, 2nd Floor
Baltimore, MD 21202-2272
(410) 333-4179

Director
Michigan Department of Labor
Victor Office Center
201 N. Washington Square
P.O. Box 30015
Lansing, MI 48933
(517) 373-9600

Director
Michigan Department of Public Health
3423 North Logan Street
Box 30195
Lansing, MI 48909
(517) 335-8022

Commissioner
Minnesota Department of Labor and Industry
443 Lafayette Road
St. Paul, MN 55155
(612) 296-2342

Director
Nevada Division of Industrial Relations
400 West King Street
Carson City, NV 97502
(702) 687-3032

Secretary
New Mexico Environmental Department
Occupational Health and Safety Bureau
1190 St. Francis Drive
P.O. Box 26110
Santa Fe, NM 87502
(505) 827-2850

Commissioner
New York Department of Labor
State Office Building - 12
Room 500
Albany, NY 12240
(518) 457-2741

Commissioner
North Carolina Department of Labor
319 Chapanoke Road
Raleigh, NC 27603
(919) 662-4585

Administrator
Oregon Occupational Safety and Health Division
Department of Consumer and Business Services,
Room 430
Labor and Industries Building
350 Winter Street, NE
Salem, OR 97310
(503) 378-3272

Secretary
Puerto Rico Department of Labor
and Human Resources
Prudencio Rivera Martinez Building
505 Munoz Rivera Avenue
Hato Rey, PR 00918
(809) 754-2119

Commissioner
South Carolina Department of Labor
3600 Forest Drive
P.O. Box 11329
Columbia, SC 29211-1329
(803) 734-9594

Commissioner
Tennessee Department of Labor
Attention: Robert Taylor
710 James Robertson Parkway
Gateway Plaza, 2nd Floor
Nashville, TN 37243-0659
(615) 741-2582

Commissioner
Industrial Commission of Utah
160 East 300 South, 3rd Floor
P.O. Box 146600
Salt Lake City, UT 84114-6600
(801) 530-6898

Commissioner
Vermont Department of Labor and Industry
120 State Street
Montpelier, VT 05620
(802) 828-2288

Commissioner
Virgin Islands Department of Labor
2131 Hospital Street, Box 890
Christiansted
St. Croix, VI 00820-4666
(809) 773-1994

Commissioner
Virginia Department of Labor and Industry
Powers-Taylor Building
13 South 13th Street
Richmond, VA 23219
(804) 786-2377

Director
Washington Department of Labor and Industries
P.O. Box 44000
Olympia, WA 98504-4000
(360) 902-4200

Administrator
Occupational Safety and Health Administration
Herschler Building, 2nd Floor East
122 West 25th Street
Cheyenne, WY 82002
(307) 777-7786

OSHA Consultation Project Directory

Alabama
7(c)(1) Onsite Consultation Program
425 Martha Parham West
P.O. Box 870388
Tuscaloosa, AL 35487
(205) 348-3033

Alaska
Department of Labor
Occupational Safety and Health
3301 Eagle Street
P.O. Box 107022
Anchorage, AK 99510
(907) 269-4954

Arizona
Consultation and Training
Division of Occupational Safety and Health
Industial Commission of Arizona
800 West Washington
Phoenix, AZ 85007-9070
(602) 542-5795

Arkansas
OSHA Consultation
Arkansas Department of Labor
10421 West Markham
Little Rock, AK 72205
(501) 682-4522

California
CAL/OSHA Consultation Service
Department of Industrial Relations
Suite 1260
45 Fremont Street
San Francisco, CA 94105
(415) 972-8515

Colorado
Occupational Safety and Health Section
Colorado State University
110 Veterinary Science Building
Fort Collins, CO 80523
(907) 491-7778

Connecticut
Division of Occupational Safety and Health
Connecticut Department of Labor
200 Folly Brook Boulevard
Wethersfield, CT 06109
(860) 566-4550

Delaware
Occupational Safety and Health
Division of Industrial Affairs
Delaware Department of Labor
820 North French Street, 6th Floor
Wilmington, DE 19801
(302) 577-3908

District of Columbia
Office of Occupational Safety and Health
District of Columbia Department
of Employment Services
950 Upshur Street, N.W.
Washington, DC 20011
(202) 576-6339

Florida
7(c)(1) Onsite Consultation Program
Division of Industrial Safety
Florida Department of Labor
and Employment Security
2002 St. Augustine Road
Building E, Suite 45
Tallahassee, FL 32399-0663
(904) 488-3044

Georgia
7(c)(1) Onsite Consultation Program
Georgia Institute of Technology
O'Keefe Building - Room 23
Atlanta, GA 30332
(404) 89402643

Guam
OSHA Onsite Consultation
Guam Department of Labor
P.O. Box 9970
Tamuning, GU 6931
(671) 475-0136

Hawaii
Consultation and Training Branch
Department of Labor
and Industrial Relations
830 Punchbowl Street
Honolulu, HI 96813
(808) 586-9100

Idaho
Safety and Health Consultation Program
Boise State University
Department of Health Studies
1910 University Drive, ET-338A
Boise, ID 3725
(208) 385-3283

Illinois
Industrial Services Division
Department of Commerce and Community Affairs
State of Illinois Center
100 West Randolph St.
Suite 3-400
Chicago, IL 60601
(312) 814-7238

Indiana
Division of Labor
Bureau of Safety, Education and Training
402 West Washington
Room W195
Indianapolis, IN 46204-2287
(317) 232-2688

Iowa
7(c)(1) Consultation Program
Iowa Bureau of Labor
1000 East Grand Avenue
Des Moines, IA 50319
(515) 281-5352

Kansas
Kansas 7(c)(1) Consultation Program
Kansas Department of Human Resources
512 South West 6th Street
Topeka, KS 66603-3150
(913) 296-7476

Kentucky
Division of Education and Training
Kentucky Labor Cabinet
1049 U.S. Highway 127, South
Frankfort, KY 4601
(502) 564-6896

Louisiana
7(c)(1) Consultation Program
Louisiana Department of Employment
and Training
P.O. Box 94094
Baton Rouge, LA70804-9094
(504) 342-9601

Maine
Division of Industrial Safety
Maine Department of Labor
State Home Station 82
Augusta, ME 04333
(207) 624-6460

Maryland
7(c)(1) Consultation Services
Division of Labor and Industry
501 Saint Paul Place, 3rd Floor
Baltimore, MD 21202
(410) 333-4210

Massachusetts
7(c)(1) Consultion Program
Division of Industrial Safety
Massachusetts Department
of Labor and Industries
1001 Watertown Street
West Newton, MA 02165
(617) 727-3982

Michigan (Health)
Michigan Department of Public Health
Division of Occupational Health
3423 North Logan Street
P.O. Box 30195
Lansing, MI 48909
(517) 335-8250

Michigan (Safety)
Michigan Department of Labor
Bureau of Safety and Regulation
7150 Harris Drive
Lansing, MI 48909
(517) 322-1809

Minnesota
Department of Labor and Industry
Consultation Division
443 Lafayette Road
St. Paul, MN 55155
(612) 297-5433

Mississippi
7(c)(1) Onsite Consultation Program
Division of Occupational Safety and Health
Mississsippi Worker's Compensation Commission
2906 N. State Street
Suite 201
Jackson, MS 39216
(601) 987-3981

Missouri
Onsite Consultation Program
Division of Labor Standards
Department of Labor and Industrial Relations
3315 West Truman Boulevard
Jefferson City, MO 65109
(314) 751-3403

Montana
Department of Labor and Industry
Bureau of Safety
P.O. Box 1728
Helena, MT 59624-1728
(406) 444-6418

Nebraska
Division of Safety, Labor and Safety Standards
Nebraska Department of Labor
State Office Building, Lower Level
301 Centennial Mall, South
Lincoln, NE 68509-5024
(402) 471-4717

Nevada
Division of Preventive Safety
Department of Industrial Relations
2500 W. Washington, Suite 104
Las Vegas, NV 89106
(702) 486-5016

New Hampshire
Onsite Consultation Program
New Hampshire Division
of Public Health Services
6 Hazen Drive
Concord, NH 03301-6527
(603) 271-2024

New Jersey
Division of Workplace Standards
New Jersey Department of Labor
STATION PLAZA 4, CN953
22 South Clinton Avenue
Trenton, NJ 08625-0953
(609) 292-3923

New Mexico
OSHA Consultation
Occupational Health and Safety Division
P.O. Box 26110
1190 St. Francis Drive
Santa Fe, NM 87502
(505) 827-4422

New York
Division of Safety and Health
State Office Campus
Building 12, Room 457
Albany, NY 12240
(518) 457-2481

North Carolina
North Carolina Consultative Services
North Carolina Department of Labor
319 Chapanoke Road, Suite 105
Raleigh, NC 27603-3432
(919) 662-4644

North Dakota
Division of Environmental Engineering
North Dakota State Department of Health
1200 Missouri Avenue, Room 304
P.O. Box 5520
Bismark, ND 58502-5520
(701) 328-5188

Ohio
Division of Onsite Consultation
Department of Industrial Relations
145 S. Front Street
Columbus, OH 43216
(614) 644-2246

Okahoma
OSHA Division
Oklahoma Department of Labor
4001 North Lincoln Blvd.
Oklahoma City, OK 73105-5212
(405) 528-1500

Oregon
7(c)(1) Consultation Program
Department of Consumer and Business Services
Labor and Industries Building
350 Winter Street, N.E., Room 430
Salem, OR 97310
(503) 378-3272

Pennsylvania
Indiana University of Pennsylvania
Safety Sciences Department
205 Uhler Hall
Indiana, PA 15705
(412) 357-2561

Puerto Rico
Occupational Safety and Health Office
Puerto Rico Department
of Labor and Human Resources
505 Munoz Rivera Avenue, 21st Floor
Hato Rey, PR 00918
(809) 754-2188

Rhode Island
Division of Occupational Health
Rhode Island Department of Health
3 Capital Hill
Providence, RI 02908
(401) 277-2438

South Carolina
7(c)(1) Onsite Consultation Program
Licensing and Regulation, SCDOL
3600 Forest Drive
P.O. Box 11329
Columbia, SC 29211
(803) 734-9614

South Dakota
Engineering Extension
Onsite Technical Division
South Dakota State University
P.O. Box 510
Brookings, SD 57007-0510
(605) 688-4101

Tennessee
OSHA Consultative Services
Tennessee Department of Labor
710 James Robertson Parkway, 3rd Floor
Nashville, TN 37243-0659
(615) 741-7036

Texas
Texas Workers' Compensation Commission
Health and Safety Division
Southfield Building
4000 South I H 35
Austin, TX 78704
(512) 440-3834

Utah
Utah Safety and Health
Consultation Service
160 East 300 South, 3rd Floor
P.O. Box 146650
Salt Lake City, UT 84114-6650
(801) 530-6868

Vermont
Division of Occupational Safety and Health
Vermont Department of Labor and Industry
National Life Building, Drawer #20
Montpelier, VT 05602
(802) 828-2765

Virginia
Virginia Department of Labor and Industry
Occupational Safety and Health
Training and Consultation
13 S. 13th Street
Richmond, VA 23219
(804) 786-6613

Virgin Islands
Division of Occupational Safety and Health
Virgin Islands Department of Labor
3012 Golden Rock
Christiansted
St Croix, VI 00820
(809) 772-1315

Washington
Washington Department of Labor and Industries
Division of Industrial Safety and Health
P.O. Box 44643
Olympia, WA 98504
(360) 902-5443

West Virginia
West Virginia Department of Labor
State Capitol, Building 3, Room 319
1800 E. Washington Street
Charleston, WVA 25305
(304) 558-7890

Wisconsin (Health)
Wisconsin Department of Health and Human Services
Section of Occupational Health
1414 E. Washington Avenue, Room 112
Madison, WI 53703
(608) 266-8579

Wisconsin (Safety)
Wisconsin Department of Industry Labor
and Human Relations
Bureau of Safety Inspection
401 Pilot Court, Suite C
Waukesha, WI 53188
(414) 521-5188

Wyoming
Occupational Health and Safety
State of Wyoming
122 West 25th, Herschler Building
2nd Floor, East
Cheyenne, WY 82002
(307) 777-7786

OSHA Area Offices

US Department of Labor - OSHA
2047 Canyon Road - Todd Mall
Birmingham, AL 35216
(205) 731-1534

US Department of Labor - OSHA
3737 Government Boulevard, Suite 100
Mobile, AL 36693
(205) 441-6131

US Department of Labor - OSHA
301 W. Northern Lights Boulevard
Suite 407
Anchorage, AK 99503
(907) 271-5152

US Department of Labor - OSHA
3221 North 16th Street, Suite 100
Phoenix, AZ 85016
(602) 640-2007

US Department of Labor - OSHA
425 West Capitol
Suite 450
Little Rock, AR 72201
(501) 324-6292

US Department of Labor - OSHA
71 Stevenson Street, Suite 415
San Francisco, CA 94105
(415) 744-7120

US Department of Labor - OSHA
1391 North Speer Boulevard
Suite 210
Denver, CO 80204
(303) 844-5285

US Department of Labor - OSHA
7935 E. Prentice Avenue, Suite 209
Englewood, CO 80111-2714
(303) 843-4500

US Department of Labor - OSHA
One Lafayette Square, Suite 202
Bridgeport, CT 06604
(203) 579-5579

US Department of Labor - OSHA
Federal Office Building
450 Main Street, Room 508
Hartford, CT 06103
(203) 240-3152

US Department of Labor - OSHA
Jacaranda Executive Court
8040 Peters Road
Building H-100
Fort Lauderdale, FL 33324
(305) 424-0242

US Department of Labor - OSHA
Ribault Building
1851 Executive Center Drive
Suite 227
Jacksonville, FL 32207
(904) 232-2895

US Department of Labor - OSHA
5807 Breckenridge Parkway
Suite A
Tampa, FL 33610
(813) 626-1177

US Department of Labor - OSHA
450 Mall Boulevard, Suite J
Savannah, GA 31406
(912) 652-4393

US Department of Labor - OSHA
2400 Herodian Way, Suite 250
Smyrna, GA 30080
(404) 984-8700

US Department of Labor - OSHA
Bldg. 7, Suite 110
La Vista Perimeter Office Park
Tucker, GA 30084
(404) 493-6644

US Department of Labor - OSHA
300 Ala Moana Boulevard, Suite 5122
Honolulu, HI 96850
(808) 541-2685

US Department of Labor - OSHA
3050 N. Lakeharbor Lane
Suite 134
Boise, ID 83703
(208) 334-1867

US Department of Labor - OSHA
1600 167th Street, Suite 12
Calumet City, IL 60409
(708) 891-3800

US Department of Labor - OSHA
2360 E. Devon Avenue
Suite 1010
Des Plaines, IL 60018
(708) 803-4800

US Department of Labor - OSHA
344 Smoke Tree Business Park
North Aurora, IL 60542
(708) 803-896-8700

US Department of Labor - OSHA
2918 West Willow Knolls Road
Peoria, IL 61614
(309) 671-7033

US Department of Labor - OSHA
46 East Ohio Street, Room 423
Indianapolis, IN 46204
(317) 226-7290

US Department of Labor - OSHA
210 Walnut Street, Room 815
Des Moines, IA 50309
(515) 284-4794

US Department of Labor - OSHA
300 Epic Center
301 N. Main
Wichita, KS 67202
(316) 269-6644

US Department of Labor - OSHA
John C. Watts Federal Building, Room 108
330 W. Broadway
Frankfort, KY 40601
(502) 227-7024

US Department of Labor - OSHA
2156 Wooddale Boulevard
Hoover Annex, Suite 200
Baton Rouge, LA 70806
(504) 389-0474

US Department of Labor - OSHA
U.S. Federal Building
202 Harlow Street,
Room 211
Bangor, ME 04401
(207) 941-8177

US Department of Labor - OSHA
300 West Pratt Street
Suite 280
Baltimore, MD 21201
(410) 962-2840

US Department of Labor - OSHA
639 Granite Street, 4th Floor
Braintree, MA 02184
(617) 565-6924

US Department of Labor - OSHA
Valley Office Park
13 Branch Street
Methuen, MA 01844
(617) 565-8110

US Department of Labor - OSHA
1145 Main Street, Room 108
Springfield, MA 01103-1493
(413) 785-0123

US Department of Labor - OSHA
801 South Waverly Rd.
Suite 306
Lansing, MI 48917-4200
(517) 377-1892

US Department of Labor - OSHA
Federal Courts Bldg.
110 South 4th Street, Room 116
Minneapolis, MN 55401
(612) 348-1994

US Department of Labor - OSHA
3780 I-55 North
Suite 210
Jackson, MS 39211
(601) 965-4606

US Department of Labor - OSHA
6200 Connecticut Avenue, Suite 100
Kansas City, MO 64120
(816) 483-9531

US Department of Labor - OSHA
911 Washington Avenue
Room 420
St. Louis, MO 63101
(314) 425-4249

US Department of Labor - OSHA
19 N. 25th Street
Billings, MT 59101
(406) 657-6649

US Department of Labor - OSHA
Century Station, Room 438
300 Fayetteville Street Mall
Raleigh, NC 27601
(919) 856-4770

US Department of Labor - OSHA
220 E. Rosser, Room 348
P.O. Box 2439
Bismarck, ND 58501
(701) 250-4521

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*These states and territories operate their own OSHA-approved job safety and health programs (Connecticut and New York plans cover public employees only). States with approved programs must have a standard that is identical to, or at least as effective as, the federal standard.

Appendix F: Suggested Readings

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